LEGISLATIVE LIBRARY OF BRITISH COLUMBIA
3 3298 00312 9427

THE BRITISH COLUMBIA CORONERS SERVICE

Mandate

The British Columbia Coroners Service is responsible by statute (*Coroners Act*) for the investigation and certification of all unnatural, unexpected, unexplained or unattended deaths. The Coroners Service is a fact-finding, not a fault-finding, agency. It makes recommendations to improve public safety and prevent deaths in similar circumstances.

Historic Development

The office of the coroner is one of the oldest common law institutions, with references dating as far back as the time of Saxon King Alfred in 925 A.D. The first detailed statute concerning coroners was the *Statute of Westminster* of 1275. The coroner was known as a "Keeper of the pleas of the Crown" or "Crowner" from which the term "coroner" evolved.

The former utility of the coroner as a protector of Crown revenue, or as an agency for bringing suspects to trial, is no longer a consideration. However, what does remain constant in the face of this evolution is the continuing concern with the fact of death and the unchanged interest of the public in the protection of its members. The death of a member of society is a public fact. The circumstances that surrounded that death and whether it could have been avoided are matters of interest to all members of the community. In this sense, the coroner exists to provide a truly public service, both individually and collectively.

Each province and territory in Canada operates its own sudden death inquiry system. Coroners are governed by the BC *Coroners Act* proclaimed in 1979.

Organizational Structure

The Coroners Service is an independent agency, falling under the Ministry of Public Safety and Solicitor General for administrative and budget purposes. The Chief Coroner, located in Burnaby, supervises the Coroners Service. There are a total of five[1] regional offices, with one in each of the following cities: Victoria, Vancouver, Surrey, Kelowna, and Prince George. Each of these offices is led by a Regional Coroner.

In 2001, the Coroners Service had 37 full-time employees, with six of these functioning as full-time coroners. There were approximately 89 appointed fee-for-service coroners who provided services to local and sometimes remote communities.

Responsibilities

The responsibilities and functions of the BC Coroners Service include:

1. Ascertaining and clarifying the facts of all unexpected and unnatural deaths in BC to determine the identity of the deceased, and how, when, where and by what means he or she died.

2. Ensuring that no death is overlooked, concealed or ignored.

[1] In 2001, there were eight regional offices. However, as these eight have since been collapsed into five, and our database has been updated to accommodate that change, the Coroner region statistics presented in this report are based on the current status.

DOC
BC
C628
B
2001
c.3

LEGISLATIVE LIBRARY VICTORIA, B.C. MAY 15 2006

3. Producing a judicial, public document, either a Judgement of Inquiry or a Verdict at Coroner's Inquest, that reports on the findings of the coroner's investigation. These documents form the official record of the identity of the deceased and how, when and where he or she died. The medical cause of death and classification are noted. This serves the general public interest and adds to the sum of knowledge in the fields of forensic science, epidemiology, public safety and public health.

4. Making recommendations, where appropriate and feasible, to both public and private agencies, so that a similar death is less likely to occur in the future. The prevention of death forms a critical part of the overall mandate of the BC Coroners Service.

5. Conducting inquests (quasi-judicial court proceedings) when mandated by the *Coroners Act* or when there is a strong public interest in the circumstances of the death or potential for prevention of death in similar future circumstances. An inquest publicly presents all evidence relating to the death, focuses community attention, and often makes recommendations which may help prevent future deaths.

6. Collecting death information, statistical analysis, and research materials.

7. Developing in-depth position papers about frequently recurring incidents in an effort to prevent further deaths from a particular specific cause or failing.

The Coroners Service has three major program areas: investigative, judicial and preventative.

INVESTIGATIVE

Coroners require a careful examination of the circumstances leading up to a death to understand why the individual died. Pathologists, toxicologists, forensic investigators and medical investigators may be used to provide assistance.

Pathology

In deciding whether or not an autopsy is necessary to determine the cause and manner of death, a careful examination of the circumstances leading up to the death is undertaken. In general, if a reasonable presumptive cause of death can be deduced after a careful examination of the body and the scene of death and in consideration of the deceased's medical history, an autopsy may not be necessary.

The forensic autopsy is a specialized autopsy. There is a great difference between a hospital autopsy and a forensic autopsy. Hospital autopsies are directed towards substantiating the accuracy of a diagnosis and therapy instituted during the course of an illness as well as determining the immediate cause of death.

The coroner authorizes a forensic, or medico-legal, autopsy to determine the cause of death where it cannot otherwise be determined; to collect evidence from the body; to document findings useful in clarifying time and circumstances of death; and finally, to obtain evidence aiding in the identification of the body.

In British Columbia, the Coroners Service retains the services of pathologists who conduct medico-legal autopsies on a fee-for-service basis.

In 2001, the Coroners Service ordered 2694 autopsies.

Toxicology

Coroners authorize toxicology testing when it is required to establish or confirm the cause and manner of death. For the most part, toxicology testing is provided on a fee-for-service basis at the Provincial Toxicology Centre, an accredited laboratory, located at Riverview Hospital in Port Coquitlam, BC. In cases also under criminal investigation, the RCMP Crime Laboratory conducts toxicology testing. Some toxicology testing is performed at regional hospitals.

In 2001, 2200 toxicology tests were ordered by the Coroners Service.

Forensic Identification

One of the primary responsibilities of the Coroners Service is the identification of the deceased in all deaths reported to the coroner. When identification cannot be visually confirmed, forensic services such as fingerprint analysis, odontology, anthropology, osteology and DNA studies, are utilized.

Medical Investigative Assistance

When coroner cases involve complex medical facts, the Medical Review Unit provides guidance and assistance in the investigation of medical issues by acting as a resource for medical information, liaising with medical and nursing staff and Health Authorities, identifying trends in health care factors which contribute to death and making recommendations that may prevent future deaths.

JUDICIAL

Coroners' investigations may be concluded by one of two procedures: Judgement of Inquiry or Inquest.

Inquiry

The most common process is for the coroner to conduct an inquiry and prepare a report for the Chief Coroner as provided by Section 20 of the *Coroners Act*. A coroner's inquiry is a quasi-judicial process conducted without a jury. The coroner interviews witnesses and gathers and reviews records and documents prepared by other agencies to determine the facts. The coroner's report, called a *Judgement of Inquiry*, outlines the circumstances of the death and confirms the identity of the deceased, when and where the death occurred and the medical cause of death. The coroner classifies the death as natural, accidental, suicide, homicide or undetermined. Recommendations can be made to public and private agencies, suggesting changes or improvements aimed at preventing similar deaths in the future.

Inquest

An inquest is a quasi-judicial hearing held in an open forum where witnesses are subpoenaed to testify under oath before the presiding coroner and a jury of five persons. An inquest is not a forum to resolve civil disputes or to conduct prosecutions. An inquest is not a trial and a coroner is not a judge. The proceedings are investigational as opposed to accusatory or adversarial. There is no "accused" or "defendant," and no "parties" or "lis." There are several reasons to hold an inquest. The sections of the *Act* which outline the circumstances under which an inquest is held are:

- Section 10, which makes it mandatory to hold inquests into deaths of persons in police custody;

- Section 18, which provides for the calling of an inquest when the coroner determines it to be "necessary;"

- Section 21, which states that a coroner conducting an inquiry may, for reasons specified in Section 21, change the inquiry to an inquest and summon a jury for that purpose.

Over time, these latter two sections have been generally interpreted to call for an inquest for the following reasons:

1. If there are significant public concerns regarding the circumstances;
2. If a witness is refusing to provide evidence to a coroner conducting an inquiry;
3. If agencies, institutions, or interest groups are legitimately pointing out concerns worthy of public attention.

The Attorney General may also, under special circumstances, direct an inquest be held as provided in Section 23 of the *Coroners Act*.

Inquest proceedings begin with the presiding coroner explaining the mandate to the jury and the jury's responsibilities under the *Coroners Act*. The coroner reviews applicable sections of the *Act* for the information of the jury and gives a short summary of facts relating to the death. Witnesses are then called and examined by coroner's counsel, the coroner, members of the jury, and persons "granted standing." Persons are given "standing" if their interests may be affected by evidence called. Persons with standing, or their representative, may participate fully in the inquest by asking questions and calling evidence. Once all the evidence has been given, the coroner adjourns the court and prepares a summation and overview of the evidence presented. The hearing is then reconvened and the summation is given to the jury. The jury prepares its verdict, which may be unanimous or by majority. The verdict and findings must not make any finding of legal responsibility or express any conclusion of law.

The *Coroners Act* provides no power to order change. The coroner, however, submits the jury's recommendations to the Chief Coroner for dissemination to appropriate persons, agencies, and ministries of governments. The jury recommendations must be lawful and are expected to be relevant and reasonable.

PREVENTATIVE

The prevention of death forms a critical part of the overall mandate of the BC Coroners Service. The preventative role is assisted by judicial recommendations, public awareness, and statistical analysis and research.

CORONER RECOMMENDATIONS

The Chief Coroner is responsible for bringing the findings and recommendations of coroners' inquiries and juries' verdicts to the attention of the appropriate individuals, agencies and ministries of government to assist in improving public safety and preventing similar deaths in the future.

The Coroners Service has no statutory authority to order change or to ensure that coroners' or juries' recommendations are carried out. Response is generally positive however, and most recommendations are considered and acted upon.

In 2001, the Coroners Service had a 75% response rate to its recommendations, with 66% of these responses being positive. As a direct result of coroner and jury recommendations, policies and procedures have been altered, more monitoring has occurred, and greater care and attention has been paid to conditions which might cause injury or death in the future.

In 2001, BC coroners sent approximately 4,000 recommendations from inquests and coroners' inquiries to agencies and ministries of government addressing a variety of public safety issues. A summary of the Inquest recommendations and responses are included in the Inquest Statistics portion of this report.

Research

A variety of agencies use data from coroner files in a collective review of deaths in certain categories that can be useful in provincial and/or federal accident, suicide and injury prevention strategies. These agencies are vetted by the Coroners Service and must sign a research agreement, which ensures security and confidentiality. Those agencies use coroner information in their own injury/death prevention strategies.

Red Cross

The Canadian Red Cross and The Royal Life Saving Society Canada have combined efforts to work with communities across BC and the Yukon to reduce the number of water-related fatalities and injuries. These agencies produce a joint provincial summary of drownings in BC and the Yukon. The coroner files provide the necessary data to allow these agencies to fulfil their role in educating the public, and reducing injuries and death due to drowning.

Traffic Injury Research Foundation

The Traffic Injury Research Foundation of Canada (TIRF) has used coroner files to compile data on alcohol-use related to motor vehicle fatalities since 1974. A fatality database is maintained for all provinces across Canada. This database provides a comprehensive source of objective data on alcohol use among persons fatally injured in motor vehicle accidents. This database provides a means of monitoring changes and trends and is a valuable tool for research on alcohol-impaired driving.

Underwater Council of British Columbia

The Underwater Council of British Columbia is dedicated to furthering safe diving practices. The Council undertakes to review all coroner diving files to produce a Recreational Diving Fatalities report, which summarizes circumstances and recommendations on diving deaths. This report is an invaluable reference for scuba instructors, educators and concerned scuba enthusiasts.

Canadian Agricultural Injury Surveillance Program

The Canadian Agricultural Injury Surveillance Program collects and interprets information on agricultural injury across Canada. This agency has reviewed cases identified by the coroner as 'farm' related and abstract data from the files. The results are combined with data from other provinces to form the National Registry of Farm Fatalities. A final report is produced which summarizes risks, trends, and other patterns among farm fatalities and provides farm safety specialists with an objective basis to develop and target farm safety programs in BC.

Coroners Act & Notification Requirement

Section 9 of the *Coroners Act* states the requirement for reporting a death to the coroner. This section of the *Act* requires that a person immediately notify a coroner or a peace officer of the facts and circumstances relating to a death where he/she has reason to believe that a person has died under circumstances where an investigation may be required. A peace officer notifed under this section must notify a coroner. The *Act* specifically requires the reporting of unnatural, unexplained or sudden/unexpected

deaths; deaths in custody; and deaths of persons to whom the *Mental Health Act* applies.

The Coroners Service is responsible for the investigation of all reported deaths to determine the identity of the deceased and when, where, how, and by what means the deceased came to his/her death.

The scope of the coroner's investigation has broadened over the years. Previously, the major emphasis was directed towards the investigation of the actual medical cause of death to the exclusion of practically all other aspects. Now, the medical cause of death is only one of many factors to be considered. The non-medical factors causing death are often equally important.

When a death is reported, the coroner focuses on who the deceased was and when, where, how and by what means death occurred. The coroner has extensive authority to collect information, conduct interviews and seize documents or other materials. The coroner may also use information received from other agencies, such as the Workers' Compensation Board in industrial related deaths, or from the local police regarding deaths that may be crime related. The coroner and the police will work closely together when crime is a factor in a reported death.

Statistical Summary of Deaths

Statistical Reporting

The Coroners Case Management System, CCMS, is an Oracle database that maintains information on all reported deaths in British Columbia. The database contains information that is critical to death prevention efforts.

CCMS was developed in 1992 to assist in tracking and summarizing case information, and is utilized for two main purposes: to facilitate enquiries and to allow for the statistical reporting of deaths. This statistical reporting allows the Coroners Service to identify problem areas relating to causal factors and to correlate evidence to support recommendations to prevent future deaths. This statistical reporting is accomplished by the use of a coding system, which is based on definitions adopted from the World Health Organization's International Classification of Diseases.

Cause of Death Codes

The primary definitions consist of the CAUSE OF DEATH and the MEANS OF DEATH:

"CAUSES OF DEATH are all those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced the injuries."

The " UNDERLYING CAUSE OF DEATH OR MEANS OF DEATH is (a) the disease or injury which initiated the train of events leading directly to death or (b) the circumstances of the accident or violence which produced the fatal injury."

It is vital to capture the precipitating event or Means of Death to provide researchers working on death prevention with meaningful research data.

Vital Statistics

The *Vital Statistics Act* requires that a coroner or physician provide a Medical Certificate of Death for each death in British Columbia. The certificate is filed with a District Registra of Births, Deaths & Marriages within 48 hours of the death. The funeral director, or person acting as such, is required to complete the Registration of Death, collect the Medical Certificate of Death and file both with the District Registrar. If the cause of death cannot be determined

within the time required, the coroner provides a provisional certificate that is later updated with the appropriate cause of death information.

Besides requiring this information for official records, the Division of Vital Statistics Research Branch utilizes mortality data for various aspects of health planning and education. It provides valuable information to health care researchers, planners and providers alike.

Classifications of Death

As of October 1993, all deaths reported to and investigated by the Coroners Service have been classified, for statistical purposes, into the following five categories:

1. A **Natural** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors.

2. An **Accident** is a death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident.

3. A **Suicide** is a death resulting from self-inflicted injury, with intent to cause death.

4. A **Homicide** is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.

5. An **Undetermined** death is defined as one that, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

The Coroners Service maintains a separate category, referred to as a **Non-coroner's Case**. A Non-coroner's Case is a natural death where none of the criteria of Section 9 of the *Coroners Act* are met. Following a brief investigation, the coroner may conclude the case as a Non Coroners case if a doctor has signed the Medical Certificate of Death.

CASELOAD STATISTICS (2001)

Total Cases (2001)

Death Class	Total Cases
ACCIDENT	1,201
HOMICIDE	82
NATURAL	1,197
NON-CORONERS	3,464
SUICIDE	470
UNDETERMINED	113
Total	**6,527**

Regional Distribution (2001)

Region *	Accident	Homicide	Natural	NonCoroner	Suicide	Undetermined
Fraser	291	30	299	1,105	147	47
Interior	294	14	281	668	94	10
Island	238	15	257	832	81	20
Metro	229	15	249	650	110	26
Northern	149	8	111	209	38	10
Total	**1,201**	**82**	**1,197**	**3,464**	**470**	**113**

* - In 2001, the Coroners' Service consolidated the Victoria and Nanaimo Regional offices into one region (Island), the Fraser Valley and Lower Mainland Regional offices into one region (Fraser), and the Kelowna and Kamloops Regional offices into one region (Interior)

Regional Caseload Review (1996 - 2001)

Region	2001	2000 **	1999	1998	1997	1996
Fraser	1,919	1,973	2,709	2,983	3,014	3,154
Interior	1,361	1,418	1,868	2,035	2,144	2,077
Island	1,443	1,364	1,866	1,868	1,855	2,013
Metro	1,279	1,259	1,887	2,053	1,941	1,962
Northern	525	578	676	695	625	694
Total	**6,527**	**6,592**	**9,006**	**9,634**	**9,579**	**9,900**

** - An amendment to the Coroner's Act in 2000, no longer requiring all deaths in Community Care Facilities to be reported to a coroner, has resulted in a decrease in the number of natural (expected) deaths reported to the Coroners Service

ACCIDENTAL DEATHS (2001)

Recreational	Cases
AIR	
Hang Glider	2
Other aircraft (AP/03	1
Ultra-light Aircraft	4
LAND	
Hiking/Climbing	8
Inline Skating ('00)	1
MOTORIZED	
Motorbike/ATV/Offroad	6
Power Boating	6
SNOW	
Heliskiing	1
Snowboarding	2
Snowmobiling	11
Snowskiing	6
WATER	
Canoe	6
Diving	2
Fishing	5
Kayak	3
Scuba Diving	2
Snorkelling	1
Swimming	9
White-Water Rafting	1
OTHER	
All other	12
Total	**89**

Occupational	Cases
Comm Hunt/Fish/Trap/Oth Vessel	10
Construction Site: Commercial	1
Construction Site: Residential	2
Construction Sites - other	1
Excavating/Paving/Grading	1
Forestry Sites	11
Helicopter Logging	1
Industrial	4
Industrial - Material Hand.	1
Mine, Quarry, or Oil/Gas	2
Other Place of Work	23
Railway Sites	3
School/University	2
Total	**62**

Other Accidents	Cases
Motor Vehicle	377
Alcohol/Drug Poisoning	345
Fall	142
Other	70
Fire	29
Drowning *	26
Airway obstruction	23
Carbon Monoxide	16
Exposure	12
Skytrain or Railway	5
Air Crash	3
Not yet detemined	1
Firearms	1
Total	**1,050**

* - Does not include drownings counted in the Recreational category, i.e., swimming

ACCIDENTAL MOTOR VEHICLE DEATHS (2001)

By Victim Type

Victim Type	Cases
Driver	187
Passenger	94
Commercial Truck Driver	10
Commercial Truck Passenger	1
Motorcycle - Moped	28
Pedestrian	53
Pedal Cyclist	2
Other	2
Total	**377**

Regional Distribution

Victim Type	Fraser	Interior	Island	Metro	North
Driver	61	55	17	15	39
Passenger	31	32	10	8	13
Commercial Truck Driver	3	4	1	0	2
Commercial Truck Passenger	0	0	1	0	0
Motorcycle - Moped	12	7	4	3	2
Pedestrian	14	6	9	18	6
Pedal Cyclist	1	1	0	0	0
Other	0	0	1	0	1
Total	**122**	**105**	**43**	**44**	**63**

CHILD DEATH REVIEW (Ages 0 - 18 yrs)

Total Cases Reported (1997 - 2001)

Death Class	2001	2000	1999	1998	1997
ACCIDENT	95	100	109	93	109
HOMICIDE	5	14	11	4	21
NATURAL	40	39	55	49	66
NON-CORONERS	27	36	46	45	50
SUICIDE	11	30	22	17	29
UNDETERMINED	15	7	9	13	11
Total	**193**	**226**	**252**	**221**	**286**

Age Distribution

Age Group	2001	2000	1999	1998	1997
0 to 11 months	48	54	76	68	89
1 to 4 years	23	19	29	28	31
5 to 9 years	20	12	16	21	31
10 to 14 years	24	25	35	27	34
15 to 18 years	78	116	96	77	101
Total	**193**	**226**	**252**	**221**	**286**

Accidental Child Deaths by Means of Death

Means of Death	2001	2000	1999	1998	1997
Motor Vehicle	41	60	69	53	62
Drowning	12	15	14	14	11
Alcohol / Drug Poisoning	5	4	3	4	4
Airway Obstruction	3	2	7	3	5
Fall	4	2	0	2	5
Fire	13	6	1	5	2
Air Crash	0	0	2	0	0
Exposure	2	1	1	1	0
Firearms	0	0	0	0	2
Dirt Bike / ATV / Snowmobile	4	2	3	1	3
Other	11	8	9	10	15
Total	**95**	**100**	**109**	**93**	**109**

SUDDEN INFANT DEATH SYNDROME (SIDS)

SIDS Ten-Year Review (1992 - 2001)

Case Year *	Cases
1992	63
1993	50
1994	40
1995	50
1996	25
1997	24
1998	16
1999	14
2000	9
2001	5

* - Decreases in the number of SIDS deaths in recent years may be, at least in part, attributable to changes in how the SIDS cause of death has been applied. A case previously classified as Suddent Infant Death Syndrome (SUDS) may more recently be classified as Sudden Unexpected Death in Infancy (SUDI)

SIDS Regional Distribution

Region	2001	2000	1999	1998	1997	1996	1995	1994	1993	1992
Fraser	1	6	4	4	8	9	14	16	12	19
Interior	0	0	2	4	2	2	9	5	7	7
Island	4	0	5	5	8	9	14	12	15	17
Metro	0	1	1	1	2	2	4	4	5	14
Northern	0	2	2	2	4	3	9	3	11	6
Total	**5**	**9**	**14**	**16**	**24**	**25**	**50**	**40**	**50**	**63**

SUICIDES

BC Suicide Rates per 100,000

Case Year	Cases	Rate per 100,000
2001	470	11.5
2000	484	12.0
1999	498	12.4
1998	509	12.8
1997	583	14.8
1996	557	14.4
1995	534	14.1
1994	513	14.0
1993	492	13.8
1992	514	14.8
1991	489	14.5
1990	426	12.9
1989	489	15.3
1988	456	14.6
1987	459	15.0

BC Five-Year Suicide Review (1997 - 2001)

Age Category	2001	2000	1999	1998	1997
12 and under	0	0	0	0	3
13 - 19	15	35	23	22	37
20 - 29	55	84	68	74	95
30 - 39	99	94	107	107	129
40 - 49	116	105	113	131	128
50 - 59	95	72	88	77	80
60 - 69	43	42	40	42	49
70 - 79	28	31	36	31	39
80 and over	19	20	23	24	23
Age unknown	0	1	0	1	0
Total	**470**	**484**	**498**	**509**	**583**

BC Five-Year Suicide Review (cont'd)

Gender	2001	2000	1999	1998	1997
Female	107	124	102	117	124
Male	363	360	396	392	459
Total	**470**	**484**	**498**	**509**	**583**

Region	2001	2000	1999	1998	1997
Fraser	147	127	134	140	159
Interior	94	95	94	98	117
Island	81	110	110	117	122
Metro	110	110	109	113	133
Northern	38	42	51	41	52
Total	**470**	**484**	**498**	**509**	**583**

Suicides by Method of Death	2001	2000	1999	1998	1997
Hanging	123	149	152	139	160
Suffocation / Smothering / Other	8	14	17	16	18
Carbon Monoxide Poisoning	40	50	54	72	59
Drowning	20	24	16	21	26
Fall	35	37	27	24	43
Firearms	90	84	115	103	137
Stabbing / Incised Injuries	23	14	11	10	14
Alcohol / Drug Poisoning	111	89	83	111	96
Other Poisoning	6	4	9	2	9
Skytrain / Railway	6	7	6	5	5
Motor Vehicle Accident	1	5	7	3	3
Fire	4	1	0	1	5
Other	3	6	1	2	8
Total	**470**	**484**	**498**	**509**	**583**

Illicit Drug Overview

In June 1993, the Minister of Health and the Attorney General of BC announced in the Legislature the appointment of the Chief Coroner to head up a task force to inquire into what appeared to be an inordinately high number of deaths associated with the illicit use of heroin. Deaths due to the use of illicit drugs became an epidemic in British Columbia increasing from 39 deaths in 1988 to 361 in 1993 as highlighted by the table below:

BC Illicit Drug Deaths

Year	Total
1988	39
1989	67
1990	82
1991	124
1992	164
1993	361
1994	317
1995	224
1996	312
1997	310
1998	417
1999	277
2000	248
2001	246

This table represents the number of Non-Therapeutic (Illicit) drug deaths in British Columbia where the CAUSE OF DEATH was due to or a consequence of an ILLICIT DRUG OVERDOSE. This category includes cocaine, heroin and illicitly purchased methadone. This table does NOT include cases where illicit drugs may have contributed to but were not the cause of death.

BC Illicit Drug Deaths cont'd

Region

	2001	2000	1999	1998	1997	1996
Fraser	74	78	90	104	90	75
Interior	25	24	15	36	17	19
Island	45	40	48	58	43	42
Metro	94	95	116	199	148	163
Northern	8	11	8	20	12	13
Total	**246**	**248**	**277**	**417**	**310**	**312**

Gender

	2001	2000	1999	1998	1997	1996
Female	53	41	49	74	44	57
Male	193	207	228	343	266	255
Total	**246**	**248**	**277**	**417**	**310**	**312**

Age Groups

	2001	2000	1999	1998	1997	1996
20 and Under	7	7	10	12	6	16
21 to 30	52	38	49	73	61	77
31 to 40	97	101	111	173	141	130
41 to 50	65	73	82	122	81	74
51 to 60	19	28	24	35	17	11
Over 60	6	1	1	2	4	4
Total	**246**	**248**	**277**	**417**	**310**	**312**

INQUEST STATISTICS (2001)

Classification of Death	
Natural	2
Accident	9
Suicide	3
Homicide	1
Undetermined	0
Type of Death	
Police Custody/Lockup	
Federal Correctional Facility	1
Provincial Correctional Facility	1
Police Cell Lock-up	5
Police Custody	3
Police Shooting	1
Police Pursuit	1
Psychiatric Institute	1
Other	2
TOTAL Inquests	15
Total # of Days	**38**

These 15 Inquests resulted in a total of 103 recommendations, addressing a variety of issues. Included here is a summary of these inquests as well as of the recommendations made and the responses provided by the relevant agencies to these recommendations. These inquest descriptions are categorized by the type of death.

Correctional Facility- Federal

Case 1 of 1

On May 30, 2001, an inquest was held in Abbotsford, BC, into the death of a 56-year-old male who died on January 14th, 2000, due to a drug overdose.

The decedent was an inmate serving a federal sentence at a medium security institution. He was found by another inmate to be unresponsive in his cell, at which point cardiopulmonary resuscitation efforts were initiated by both staff and inmates. Following these initial efforts, he was transferred to the Health Care Unit within the institution, and then to hospital, where he was later pronounced dead. It is unknown whether the decedent was alone in the cell before assistance was summoned. A search of the decedent's cell failed to reveal any illicit drugs or paraphernalia. However, post-mortem examination did reveal a recent needle puncture mark inside the decedent's elbow and a lethal level of heroin in the system.

The jury found that the death resulted from morphine overdose and classified the death as accidental.

There were no recommendations made.

Correctional Facility- Provincial

Case 1 of 1

On May 1, 2001, an inquest was held in Burnaby, BC, into the death of an 18-year-old female who died on September 22nd, 1999, due to asphyxia.

The decedent was an inmate of the BC Correctional Facility for Women (BCCW). An informal head count was conducted by correctional staff, at which point water was heard to be running in the bathroom, but no response was given. Upon return of the correctional officer, the decedent was found fully suspended from the shower curtain rod in the bathroom, hanging from two pillowcases which were used to fashion a ligature. Upon assessment of the situation by a senior correctional officer, a verification process which is policy at BCCW, 9-1-1 was called. After resuscitation efforts, EHS attended the scene and she was found to be unresponsive and was later pronounced dead.

The jury found that the death resulted from asphyxia due to hanging and classified the death as a suicide.

Recommendations:

The jury made recommendations to the BC Correctional Centre for Women and the Corrections Branch of the Ministry of Attorney General. The recommendations were as follows:

- That 9-1-1 be called immediately by the Control Centre without waiting for a senior correctional officer's assessment.
- That all informal head counts include visual verification.
- That the shower bar in the bathroom be made of less sturdy material or that the support be removed. It was further recommended that the facility be inspected for any other possible supports to minimize the opportunity for hangings.

Responses to the recommendations:

- Visual verification is included in all head counts and the staff has been reminded of this requirement. One change that has been implemented following this death is the requirement that a relieving officer conduct and verify the count with the departing staff before the departure of the relieved staff in order to eliminate any confusion or error. At the time of response, this new practice was deemed to be successful.
- While serious consideration was given to the recommendation to ensure that 9-1-1 be called without assessment by the senior correctional officer, it was decided that managerial assessment of emergency situations is the preferred response so that EHS is provided with the most accurate information possible, which will assist them in determining the level of response required.
- Immediately following the death, all shower curtain rods were changed to a breakway style, as were showerheads throughout the facility. While the Corrections Branch acknowledges that they can never practically remove or replace all potential ligature attachment points, efforts have been made to reduce or eliminate as many as possible.

Police Cell Lock-Up

Case 1 of 5

On September 27, 2001, an inquest was held in Burnaby, BC, into the death of a 64-year-old male who died on September 21st, 2000, due to brain injury.

The decedent had been approached by a Vancouver Police Department officer to investigate a report of an intoxicated man causing a disturbance. He was found to be extremely intoxicated and was believed to be a danger to himself and others. He was thus handcuffed and arrested, and transported to jail where he was to be held until sober. Once it was discovered that he had an outstanding warrant for his arrest, he was transferred to a single-

person cell and placed in a recovery position. He was later found by a nurse to be unresponsive with vomitus around his mouth. Following the EHS efforts, vital signs returned and he was transported to St. Paul's Hospital where he died days later. Subsequent to this incident, an electrical operating suction device and a defibrillator were introduced to assist the Vancouver Jail nurses with medical emergencies.

The jury found that the death resulted from anoxic brain injury due to cardiac arrest caused by aspiration due to alcohol intoxication. The death was classified as accidental.

Recommendations:

The recommendations made to the BC Corrections Branch Vancouver Jail were as follows:

- That all appropriate staff in the Vancouver Jail be scheduled for immediate training on newly purchased medical equipment including the suction machine and defibrillator.
- That during each mandatory fifteen-minute check of inmates by security officers, intoxicated inmates not already in the recovery position be placed in that position.

Responses to the recommendations:

Responses from BC Corrections Branch-Vancouver Jail:

- The Vancouver Jail provided training to health care staff on the use of the suction machine, and defibrillator training was scheduled to occur by the end of November 2001 (within approximately 2 months of the inquest).
- Nursing staff was directed to review the physical position of intoxicated inmates when conducting their checks of prisoners. This practice has been included in the Nursing Procedures Manual.

Case 2 of 5

On October 29, 2001, an inquest was held in Williams Lake, BC, into the death of a 67-year-old male who died on April 18th, 2000, of pneumonia.

The decedent had been picked up by police in response to a complaint of a drunk male in public. The responding RCMP officer took the decedent into custody and transported him to the detachment. While an officer was trying to remove the decedent's boots in his cell, the decedent fell and struck his head. The ambulance crew that responded to the call transported him to hospital, where the doctor examined his head injury and noted that he was intoxicated and combative. He was transported alone back to a cell at the detachment. He later complained of chest pains and was returned to the hospital in a police vehicle. It was then determined, after a more thorough assessment, that the decedent had broken ribs which were found to have resulted from an injury that occurred 7 to 10 days prior to the arrest. The decedent's condition deteriorated over the next few days, and he was pronounced dead in hospital one week after the arrest.

The jury found that the death resulted from pneumonia due to blunt force trauma (broken ribs), inflicted by an unknown assailant, and chronic alcoholism, and classified the death as a homicide.

Recommendations:

There were 30 recommendations made by the jury at this inquest. Included here is a brief synopsis of the recommendations made.

- Those recommendations made to the Cariboo Memorial Hospital included the need to develop joint protocols with the RCMP and First Nations representatives on the assessment and care of intoxicated individuals brought to hospital, with specific attention to be paid to First Nations persons and street persons. The need to conduct a thorough physical examination of those brought in from cells or the custody of a police officer was also discussed.

• Recommendations made to the relevant RCMP detachment revolved around the need to strengthen relations with First Nations by educating the relevant First Nations Band about police policies and procedures, and by educating the police about cultural issues and differences, as well as ensuring the safety and comfort of First Nations prisoners. Recommendations to the RCMP also included the need to provide a safe secure seating area where the prisoner may sit while clothing and effects are removed.

• Those made to the RCMP Public Complaints Commission included the need for the Commission to conduct independent investigations into complaints to increase its credibility to the public.

• Recommendations made to the BC Coroners Service included the need to simplify the language in the Coroners Inquest Guide and to provide juries with more technological resources to facilitate the recommendation making process.

• Recommendations made to the relevant First Nations Band revolved around the need to improve/develop pneumonia vaccination plans for First Nations members, to improve relations with police, to develop a protocol with RCMP and hospital staff to ensure that family members of prisoners/patients are contacted when the individual is being served by police/the hospital, and the possibility of looking into the role of agencies providing shelter so that an alternative to jailing of street people can be offered and implemented.

Responses to the recommendations:

Included here is a brief synopsis of the responses provided by each agency/ministry.

Responses from the Cariboo Memorial Hospital & First Nations Band:

• The recommendation to develop a joint committee between the hospital and First Nations representatives was successful in that a committee was formed and at the time of the hospital's response, five joint committee meetings had been held. The response also indicated that the committee hoped to complete the protocol agreement within three months from the time of the response.

• With respect to the need for a thorough physical examination, the response indicated that the hospital's Critical Care Committee reviewed the assessment forms and adopted one that allows the emergency room staff to draw observations on the anterior and posterior pictures of the adult body.

Responses from the RCMP & First Nations Band:

• The recommendation with respect to developing a joint committee with the RCMP and First Nations representatives was successful in that a committee was formed and a meeting had already taken place at the time of their response.

• The recommendation for the First Nations Band and the RCMP to learn more about one another was implemented and a meeting between the relevant band and the relevant RCMP detachment was held. Furthermore, the participation of officers in First Nations community activities and learning opportunities was encouraged.

• The recommendation to provide a seating area for prisoners was also implemented.

Responses from the RCMP Public Complaints Commission:

• In response to the recommendation for the independence of investigations, the RCMP stated that the conclusions reached by the jury at inquest with respect to the RCMP's involvement in the death were consistent with the RCMP's investigation, including the public complaint investigation. The response also indicated that while they agree that the Commission would better serve the public by conducting its own independent investigation when a complaint is made and a death is involved, a shortage of resources had prohibited them from doing so.

Responses from the BC Coroners Service:

• In response to the recommendation, the BC Coroners Service indicated that the rewording of the Inquest Guide would be considered as part of

the policy review/update of the BC Coroners Service Judicial Services Manual.

• The response also indicated that the feasibility of having laptops/printers available for jury members would be discussed with the Regional Coroners around the province and that action would be taken as deemed appropriate.

Case 3 of 5

On February 22, 2001, an inquest was held in Burnaby, BC, into the death of a 38-year-old male who died on June 6th, 2000, of hypertensive cardiovascular diseases.

The decedent had been picked up by police in response to calls of him behaving erratically in public and making several threats with a knife. He was charged for uttering threats and for possession of a dangerous weapon and was taken to Vancouver Jail, where his violent and erratic behaviour continued through to the next morning. Two courses of sedatives were administered, and when the decision was made to administer a third course, the decedent was discovered unresponsive in his cell. At the time of this incident, no policy was in place requiring recording of the camera in the mentally disordered offender cell in which the decedent was the sole occupant. Autopsy findings revealed hypertensive cardiovascular disease and atherosclerotic coronary artery disease. Secondary findings included cirrhosis of the liver, which may have adversely affected the metabolism of the sedative medication.

The jury found that the death resulted from hypertensive cardiovascular diseases due to atherosclerotic coronary artery disease and classified the death as natural.

Recommendations:

• Recommendations made to the Vancouver Police Department revolved around training for patrol constables to aid them in understanding medical issues when confronted by unusual, manic behaviour, and the need to more accurately document the transporting of persons in the paddy wagon.

• Recommendations made to the BC Corrections Branch, Vancouver Jail, revolved around the monitoring of mentally disordered offender cells and of inmates who are administered medication, and the training and resource availability of Health Care Unit staff and correctional officers.

Responses to the recommendations:

Responses from Corrections Branch:

• Initiatives to improve surveillance, monitoring, and in-cell safety of disordered offenders were completed.

• Efforts were being made to explore new resource opportunities, and the training of the staff in the use of the new equipment was being developed.

• Finally, in response to the recommendations, medical staff provisions were placed under review. In the meantime, the Branch believed regular readiness drills were appropriate.

Case 4 of 5

On November 19, 2001, an inquest was held in Campbell River, BC, into the death of a 27-year-old male who died on March 2nd, 2001, due to respiratory depression.

In the week preceding the decedent's death, he had come into contact with the police and with the hospital on several occasions. On the day of his death, the decedent had been taken into custody by police in response to complaints from the public regarding a male wandering in traffic. He was found to be intoxicated in public, and the police were concerned about his safety. He was taken to a police cell, where he was later found unresponsive in his sleep. Upon arrival of EHS, resuscitation efforts were commenced and were continued in the emergency room where the decedent was transported and where he was later pronounced dead.

At inquest, it was revealed that the attending EHS staff in this case felt that there was a delay in

access into the decedent's cell. Witness testimony at the inquest also revealed that the decedent had been placed on the methadone program in the week prior to his death, and that he continued to take street drugs as well as other medications ordered for him by other physicians. Furthermore, it was revealed at inquest that the decedent's toxicology analysis indicated the presence of a number of drugs, including a near lethal level of methadone. Finally, it was revealed that it is not routine procedure for pharmacists to access the PharmaNet, a program which lists all medications that a person is receiving.

The jury found that the death resulted from respiratory depression due to drug overdose and classified the death as accidental.

Recommendations:

There were several recommendations made. Included here is a brief synopsis of the recommendations made to each agency/ministry.

- Recommendations made to the City of Campbell River and the Police Academy Justice Institute of BC revolved around training for drug and alcohol recognition and classification, as well as the need to review policies and procedures regarding the resuscitation of a prisoner who is unconscious and unresponsive.
- Those recommendations made to the BC Ambulance Services and the RCMP indicated the need to review procedures regarding EHS access into RCMP buildings in an emergency. More specifically, the recommendation asked for EHS vehicles to be provided with a garage door opener.
- Those made to the College of Physicians and Surgeons, to the Registered Nurses Association of BC, and to the BC Medical Association revolved around the need to have provincially funded methadone programs with more accessibility for clients.
- Those made to the BC Drug and Poison Information Centre and to Drug and Alcohol Programs revolved around the need to have more facilities for detoxification in the relevant community (Campbell River) and the need to extend the length of these programs.
- Those made to the College of Pharmacists revolved around the need for PharmaNet to flag Methadone program clients for their high risk narcotics use, the need to have a separate registry within distributing pharmacies for Methadone Program clients, and the need to facilitate access to PharmaNet to ensure complete information is available to pharmacists.
- Those made to the BC Medical Association and to the RCMP revolved around the need to improve communication between services.

Responses to the recommendations:

Responses from the Police Academy:
- Regarding training, the Police Academy responded that it is a pre-employment requirement of all municipal police departments that new officers entering the recruit training program be qualified in CPR techniques and be given instruction in Field Sobriety Testing that includes recognition of intoxication by alcohol and/or drugs.
- Finally, the Police Academy responded by stating that they have no control over individual department policy and procedure regarding the resuscitation of a prisoner who is unconscious and unresponsive.

Responses from the City of Campbell River:
- The City of Campbell River responded by stating that the requirement of the RCMP is that the guards be trained to the standard of the regular members and that at the time of response, all guards were certified to that standard.
- With respect to the resuscitation policies and procedures, the City of Campbell River stated that they have been reviewed and that the City acknowledges that prisoner safety is of utmost importance.

Responses from the RCMP:
- With respect to reviewing policies and procedures regarding resuscitation of a prisoner who is unconscious and unresponsive, the RCMP stated that

guards and members are fully trained in CPR, and that the policies have been reviewed with the guards.

- With respect to the recommendation to review classification regarding intoxication description, the response was that the local detachment reviewed this recommendation and found that the then-present polices were being adhered to.
- With respect to the sharing of information between services and/or ministries involved, it was indicated in the RCMP response that the RCMP Legal Services was developing a provincial protocol with Health Authorities for the disclosure of patient information when and where appropriate by law and that the routine sharing of medical information as a preventative measure was not possible as this information is privileged.

Responses from BCAS and RCMP:

- The response from the BCAS and the RCMP indicated that a meeting would be held to discuss and implement improvements to ensure access is not delayed again in the future. It was found that the distributing of keys or door openers to any other agencies was not feasible for security reasons.

Responses from the Registered Nurses Association:

- The Registered Nurses Association responded by stating that they were unable to take any direct action on this recommendation as they do not have authority over the development or operations of methadone programs in BC.

Responses from the College of Physicians and Surgeons of BC:

- The College of Physicians and Surgeons of BC responded by emphasizing, amongst other things, that the decedent was an unstable heroin addict who was also using other drugs in spite of being advised of the rules of the Methadone Program.

Responses from the Vancouver Island Health Authority:

- That new funds would be used to support a Mobile Crisis Response Team for Central and North Island and that this new project was intended to be operational in early 2004.
- That the gap in the Mental Health and Addictions Services continuum would be addressed and coordination and communication between community and hospital services would be enhanced.
- Furthermore, as part of the MHAS review of services, optimal lengths of stay in all programs within the service continuum were being examined.

Responses from the College of Pharmacists of BC:

- In their response, the College of Pharmacists indicated that PharmaNet is a mandatory computerized medication profile system, that every prescription dispensed in a community pharmacy in BC must be entered into the patient's medication profile, and that the pharmacist is supposed to review the profile and base their clinical decisions on the information before them.
- The College also indicated that there exists the requirement for all prescriptions for narcotics to be kept in a file separate from regular prescription drugs.

Case 5 of 5

Commencing November 27th, 2000, and ending on April 20, 2001, an inquest was held in Chilliwack, BC, into the death of a 45-year-old male who died on December 28th, 1999, due to a blunt head trauma.

The decedent called 9-1-1 and complained of having difficulties with his mental illness. When the responding officers returned to the residence a second time that evening, and found the decedent to be argumentative and combative, the decision was made to arrest him for drunkenness in a public place and he was transported to the detachment, where he continued to be loud, verbally abusive and intoxicated. When efforts were made to remove the decedent's shoes, the removal of which is policy, the decedent became combative, resulting in his fall on the concrete. After being left in the prone position for a short while, the decedent was taken to hospital by Emergency

Health Services. After several tests and transfers, he died in hospital. Since the incident, the RCMP directs that any serious incident, such as a serious injury or death in cells, be assigned to a division Major Crime Unit investigator.

The jury found that the death resulted from a blunt head trauma due to blows to the head and classified the death as accidental.

Recommendations:

There were 20 recommendations made. Included here is a brief synopsis of these recommendations.

• The recommendations made to the Chilliwack RCMP Detachment were in regards to the upgrading of the current audio and video surveillance system and also in regards to the need to ensure adequate First Aid training for RCMP and for civilian guards. For 9-1-1 specifically, the recommendations included the need for 9-1-1 to pass all pertinent information to RCMP and to supervisors when appropriate, and the need for specific policies and planned routes of action to be outlined for callers to avoid confusion.

• The recommendations made to the Fraser Valley Health Region and the Minister of Health included the need to appropriately monitor intoxicated and head injured patients and the need for an in-service workshop for nursing staff to review assessment procedures.

Responses to the recommendations:

Included here is a brief synopsis of the responses provided by each agency/ministry.

Responses from the RCMP:
• There were changes made to the quality of video recording, but at the time of response, no consideration had been given to the implementation of policy requiring audio recordings. With respect to the training concerns, it was found, after an internal administrative review following the incident, that the level of training at the time of the incident was in full compliance with the policy.

Responses from the Fraser Valley Health Region:
• The response indicated that recommendations were being reviewed and that the organizational goal was to create system-wide consistency by identifying best practices in the industry and applying those practices authority-wide, including the Chilliwack General Hospital.
• A neurological workshop was offered to staff at the Chilliwack General Hospital wherein the issues identified in the recommendation were addressed, along with other critical aspects of nursing assessment and intervention.
• Finally, an authority-wide Emergency Services team was scheduled to review practices within the authority of the Fraser Valley Health Region, as well as provincially, and to develop an improvement plan to action the recommendations.

Police Custody

Case 1 of 3

On June 28, 2001, an inquest was held in Chilliwack, BC, into the death of a 56-year-old male who died on January 12, 2001, due to pneumonia.

The decedent had been picked up by police in response to a 9-1-1 call from a local resident. He was found intoxicated on the side of the road and out of concern for his safety, he was taken to the police detachment. Shortly upon arrival, while still in the back seat of the police vehicle, the decedent was found to be unresponsive. Resuscitation efforts began and Emergency Health Services was summoned. The decedent was transferred to Chilliwack General Hospital, where he later died in the Intensive Care Unit.

The jury found that the death resulted from lobar pneumonia due to chronic alcoholism, and classified the death as natural.

There were no recommendations made.

Case 2 of 3

On May 14, 2001, an inquest was held in Squamish, BC, into the death of a 47-year-old male who died on August 20, 2000, due to a drug overdose.

The decedent had been approached by RCMP officers in response to complaints of a male staggering in a ditch and roadway areas near a highway. Upon arrival, the decedent was found lying in a ditch. Attempts were made by the officers to ascertain the circumstances of his behaviour and the extent of any injuries. When the decedent was advised that the ambulance was on its way, he became irrational and attempted to return to the highway. When the officers restrained the decedent and applied handcuffs, he suddenly went limp and, despite emergency efforts, died in hospital. It was revealed that the cocaine levels were over the lethal levels, making all emergency efforts virtually impossible.

The jury found that the death resulted from acute cocaine overdose and classified the death as accidental.

There were no recommendations made.

Case 3 of 3

On April 25th, 2001, an inquest was held in Colwood, BC, into the death of a 33-year-old male who died on August 21st, 2000, of a cardiac arrest.

The decedent had been picked up by a police officer in response to a call for help made by the decedent himself, as well as calls from members of the public describing his unusual behaviour. Upon arrival of a second officer, it was decided that the decedent be transported to hospital for assessment pursuant to the *Mental Health Act*, where he was taken by this second officer. En route, the decedent began to kick the barred rear side windows of the police vehicle and he managed to exit the vehicle. He was restrained until the original officer arrived to the scene. When handcuffing was completed, and the decedent was rolled over, he was found to be unresponsive. The attending paramedics initiated cardiac resuscitation protocols, which were continued en route to the hospital and in the hospital emergency department, but no response was exhibited. Post-mortem examination revealed lethal cocaine levels.

The jury found that the death resulted from cardiac arrest caused by acute cocaine intoxication and classified the death as accidental.

Recommendations:

- Recommendations made to the Inspector of the relevant police detachment included the installation of protective equipment on the rear window of police cruisers, similar to that done on the side windows, to protect its integrity. The review of staffing levels with a view to establish minimum resource standards for detachments was also recommended. Finally, it was stated in the recommendations that overall safety would be enhanced if two officers transport mentally distressed persons.

Responses to the recommendations:

- The Chief Superintendent of the relevant RCMP division felt that by placing bars on the side and back windows, access to the prisoner or the back seat in the event of a car accident may be compromised and that safety issues as well as any civil liability implications may outweigh the merit of implementing the first recommendation. This recommendation was sent to the agency's national policy centre, which expressed the same concerns and thus left the implementation as optional.
- In the response to the recommendation regarding resourcing, it was noted that the issue had been a subject of discussion at the Commissioner's Standing Committee on Member Safety and that it was assumed that the agency's members had the training and knowledge to identify situations where additional members are necessary when escorting or

arresting a violent individual. It was also noted that it is not always possible that a member be aware that a person will in fact become violent after first contact.

Police Shooting

Case 1 of 1

On June 18, 2001, an inquest was held in Burnaby, BC, into the death of a 42-year-old male who died on September 26th, 2000, due to a gunshot wound.

On the day of his death, the decedent had been approached by RCMP officers in response to a 9-1-1 call regarding a male with a gun. Upon arrival, the officers discovered the subject walking in the street with the gun and a dog was released on him when initial efforts to stop him had failed. After re-loading his gun, the decedent turned the firearm from the dog to the nearest officer. At this point, three officers within range fired until the decedent's arm holding the gun was lowered. Emergency efforts were made by the officers and were continued by paramedics en route to the emergency department, where he died shortly thereafter. Upon further investigation, it was found that the decedent had a history of making suicide threats. It was also found that when the decedent visited the emergency hospital a few months earlier and received a psychiatric assessment, it was decided at that point that the criteria necessary for committal under the *Mental Health Act* had not been met.

The jury found that the death resulted from a penetrating gunshot wound to the chest inflicted by an RCMP officer and classified the death as a suicide.

Recommendations:

- The jury had concerns around the previous psychiatric assessment of the decedent and stated that busy hospital emergency departments are not the optimum place for assessment of persons in crisis. As such, the recommendation made to the Ministry of Health Services, the Ministry of Health Planning, and the Minister of State for Mental Health was that when a person is taken into custody under Section 28 of the *Mental Health Act*, he/she be attended by a physician in a location other than a hospital emergency room.

Response to the recommendations:

- With respect to the recommendation regarding the location where to conduct an assessment, it was indicated in the response of these agencies that staff does assess patients either in an interview room within close proximity to the emergency room or within the emergency room.
- It was also indicated in the response that a number of health authorities have developed mobile crisis teams and other bridging mechanisms between the community and the hospital.
- Finally, it was indicated that the Ministry of Health Services staff was working at the time with the health authorities to develop policies and guidelines aimed at improving services, as well as with the Ministry of Public Safety and Solicitor General on a number of police and mental health issues.

Police Pursuits

Case 1 of 1

On March 27, 2001, an inquest was held in Barriere, BC, into the death of a 21-year-old male who died on May 26, 2000, due to a massive skull fracture.

The decedent was an inmate in a low risk facility from which he escaped. Shortly after the escape, a vehicle that was reported to have been stolen was spotted being driven by a person who the officer believed may have been the escapee. Efforts were made to minimize the chance of a high speed chase. The stolen vehicle collided with trees and the driver, one of the two escapees in the vehicle, died suddenly.

The jury found that the death resulted from massive skull fracture from a vehicle collision that occurred while the decedent was trying to escape the RCMP, and classified the death as accidental.

Recommendations:

The jury had concerns around the Correctional Centre's classification of the decedent as 'low risk' as he had a history of escapes and assaults on police officers. The jury also had concerns around the officers' knowledge of the history of the escapee, and how this knowledge would have changed their approach.

As such, there were two recommendations that were made and forwarded to the Kamloops Regional Correctional Centre:

- The first revolved around the better screening of inmates.
- The second revolved around the need for the Correctional Centre to give more information to the RCMP at the time of reporting an escape.

Responses from Bear Creek Correctional Centre:

- With respect to the screening of inmates, the response indicated that inmates are classified on a basis of risk, and that inmate classification is a complex and fluid exercise that includes a review of past conduct and the history of criminal behaviour, as well as the inmate's response to supervision and program activities. The decision in this case was taken seriously and was found to be in accordance with Corrections Branch policy.
- The Corrections Branch maintained that relevant information concerning the escaped inmates was forwarded and received by police authorities in a prompt and timely manner. It was also noted in their response that the RCMP have their own offender data systems which provide information on the offenders which is often more expansive and complete than information maintained by the Corrections Branch.

Psychiatric Institute

Case 1 of 1

On April 25, 2001, an inquest was held in Burnaby, BC, into the death of a 22-year-old male who died on March 12th, 2000, due to asphyxia.

The decedent was a patient at the Forensic Psychiatric Institute. RCMP officers responded to a call from staff for assistance regarding a male patient found hanging. Upon arrival, resuscitation efforts were already in progress. These efforts were discontinued shortly thereafter. It was found that the decedent had used a ligature made of a torn bed sheet tied to a metal support railing for the toilet stall wall in the ward bathroom. Subsequent to this incident, changes were made to reduce the potential of a similar future occurrence, namely the modification of the metal railing in the bathroom stalls, which was substituted with a non-weight bearing plastic curtain.

The jury found that the death resulted from mechanical asphyxia due to a hanging, and classified the death as a suicide.

There were no recommendations made.

Other

Case 1 of 2

On December 11, 2001, an inquest was held in Abbotsford, BC, into the death of a 20-year-old female who died on May 12th, 2000.

The decedent was a patient of the Methadone Program, a treatment program that she had been re-admitted to several times. The last time the decedent came to the physician's office due to symptoms of narcotic withdrawal, she was given a daily dose of methadone which had been returned to the physician by another patient, and arrangements were made to see her the next day for a daily dose of her other prescriptions. At this time, as there were no beds available at the Psychiatric Unit, the decedent returned home, where she was later found to be unresponsive in her sleep.

The jury found that the death resulted from respiratory depression due to mixed drug overdose of methadone, chloral hydrate and venlafaxine, and classified the death as accidental.

There were a total of 17 recommendations made. Included here is a brief synopsis of the recommendations made to each agency/ministry.

Recommendations:

- Recommendations made to the College of Physicians and Surgeons of British Columbia included concerns revolving around confidentiality, the need for general practitioners to consult with specialists when dealing with drug addictions and mental health issues, the training of doctors involved in specialized treatment programs, and the need to abolish the practice of recycling therapeutic drugs.
- Recommendations made to the Minister of Health Services included the need to treat persons that may fall outside of regional boundaries, the need for care facilities in the Fraser Valley Region, the need to establish resources such as a Mental Health and Substance Abuse Resource Centre, and the need for appropriate interview spaces in hospital emergencies for mentally ill patients in crisis.
- Recommendations made to the Fraser Valley Health Authority included the need for more mental health workers for the Abbotsford/Mission area, the need to upgrade the M.S.A. General Hospital to provide mental health services for a growing population, and the need to implement a dual diagnosis program.

Responses to the recommendations:

Included here is a brief synopsis of the responses to these recommendations:

Responses from the College of Physicians:
- A peer review committee of the College reviewed this case and felt that the clinical care that was provided by the physician to the decedent was inadequate and inappropriate. These concerns were passed on to the Executive Committee of the College for review and further direction.

Responses from the Minister of Health Services:
- The Minister responded by stating that all health authorities have the responsibility for ensuring health care is available and to work with other health authorities and professionals to plan for patients' access across regions. Since the inquest, there were more emergency departments connected to PharmaNet and 'Best Practices' documents were published to guide the delivery of mental health services.

Responses from the Fraser Valley Health Authority:
- In direct response to these recommendations, the following changes have been made: Fraser Health has taken responsibility for the Maple Cottage Detox to serve all of Fraser Health, which was to be moved to Surrey in order to be more central to the rest of Fraser Health; efforts have been made to situate more adolescent psychiatry beds in a new hospital in Abbotsford; plans were underway for community forums to cover topics pertaining to mental health and addictions; improvements in access to interview space in hospital emergencies for mentally ill patients were being considered across Fraser Health; and the hiring of experienced therapists has occurred and training has increased.

Case 2 of 2

On November 13, 2001, an inquest was held in Sparwood, BC, into the death of a newborn infant female who died on October 12th, 1999, due to asphyxiation.

The mother of the decedent had delivered the decedent on the toilet in the early morning hours of October 12th. Following delivery, the mother cut the umbilical cord, placed the newborn in a plastic garbage bag, and transported her outside of the home to dispose of the bag. The decedent's mother was taken to hospital where she was treated for significant loss of blood. Evidence indicated that the delivery of the newborn was consistent with that of a near full term baby. The

findings of the autopsy were reviewed by two pathologists, with the conclusion being unclear as to whether the infant had ever been live born.

The jury found that the death resulted from asphyxiation due to damage to the lungs/pneumothorax, and classified the death as accidental.

There were no recommendations made.

For more information or additional copies of this report, please contact:

Office of the Chief Coroner
Suite 2035 - 4720 Kingsway
Burnaby, BC V5H 4N2

Tel: (604) 660-7746
Fax: (604) 660-7766